THE MANY FACES OF THE MEDICAID PROGRAM

The Many Faces of Medicaid

- There is no single Medicaid program
- At least a dozen different programs fall under Medicaid
- Many types of extensions after Medicaid eligibility ends
- It is the responsibility of the local Department of Social Services or DOH to determine which programs and/or extensions the applicant is eligible for.

Medicaid Statistics

- 227,784 individuals in receipt of Medicaid or FHP in Suffolk County *(Dec. 2013 – DOH Statistics)*
  - 88,260 Children
  - 80,555 Adults (not aged or disabled)
  - 18,130 Aged (65 and older)
  - 34,790 Disabled
  - 2,559 Other
- Medicaid paid $46.5B for New York State Medicaid recipients in 2012. ($2.2B for Suffolk County recipients)

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Traditional Medicaid - Began in 1965

- Type of Program - Health Insurance
  - Fee for Service
  - Managed Care Model
- Applications Used:
  - Access NY Application
  - Medicare Savings Program Application
  - PCAP Application
  - Standard DSS Application
  - Online (for Health Exchange consumers)

Traditional Medicaid continued

- Income Guidelines – adjusted annually
  - Medicaid (MA) Standards by household size and category
- Resource Level for Individuals 65 and older, blind or disabled (2014) - adjusted annually
  - Single Person - $14,550
  - Couple - $21,450
- Effective 1/1/2010 the Resource Limits were eliminated for other applicants/recipients

Documentation Needed

- For all applications:
  - Identity
  - Age
  - Residence
  - Income
  - Household Composition
  - Other Health Insurance
  - Social Security Number (can attest)
  - Immigration Status (except Pregnant Women and Emergency Medical Treatment)

Documentation Needed continued

- For some applications
  - Health/Disability information
  - Medical Bills
  - Resources (only required for over 65, blind or disabled - in most cases can attest to amount)
  - Childcare costs when employed

Documentation Needed

- Effective October 1, 2010, individuals attesting to citizenship and social security number will not need to document citizenship or identity
- Naturalized citizens will need to continue to provide original documentation for identity and citizenship
- Individuals who have failed social security validation will need to provide original documentation for identity and citizenship

Prenatal Care Assistance Program (PCAP) - Began in 1987

- Expanded Eligibility for pregnant women
- Income Guidelines
  - Up to **223%** of Federal Poverty Level
  - No Resource Test
- Pregnant client eligible from date of case opening through two months post-partum.

Prenatal Care Assistance Program (PCAP) continued

- Applications taken at Qualified PCAP Provider sites
  - Dolan Family Health Center
  - Hudson River Health Care
  - Planned Parenthood
  - Southampton Hospital
  - Suffolk County Health Dept. Clinics
- PCAP applications are "MAGI", but retained by the local DSS offices at this time.

Expanded Levels for Children - Began in 1990

Levels of Expanded Eligibility for Children

- Children up to age 1
  - **223%** of Federal Poverty Level
- Children age 1 – 18
  - **154%** of Federal Poverty Level

Expanded Children 1 – 18

- Income Guidelines
- No Resource Test
- If child born to mother in receipt of Medicaid, child is automatically Medicaid eligible for first year.
- If child ineligible for Medicaid, can apply for Child Health Plus

Child Health Plus (CHP)

- A program for children who:
  - Do not have other health insurance
  - Are under 19 years of age
  - Are not eligible for Medicaid
- No co-payments
- Premiums may apply – based on income
- No resource test

Child Health Plus continued

- All Medicaid Managed Care Plans participate – plus Empire BC/BS
- CHP IS NOT A MEDICAID PROGRAM
- If eligible for Medicaid cannot enroll in CHP
- Children who are not citizens or eligible immigrants (and therefore ineligible for Medicaid) may receive CHP
- Must apply via the Health Exchange (NYSOH)

Family Health Plus - Began in 2001

- For adults from the age of 19 through age 64
- Cannot have other private health insurance
- Must be ineligible for Medicaid
- Administered through Managed Care Plans

New Enrollments ended 12/31/13

Program ENDS 12/31/14

Medicaid Buy-In For Working People With Disabilities - Began in 2003

- Expanded eligibility levels for working persons with disabilities allows for Medicaid coverage despite increased income
- Income Limits
  - 150% of Federal Poverty Level – No Premium
  - 250% of Federal Poverty Level
    - May require premium payment (premium program not yet implemented)
- Resource Limit
  - Household of one $20,000
  - Household of two $30,000

Medicaid Buy-In For Working People With Disabilities continued

In order to qualify, an applicant must:

- Be a New York State resident
- Be certified disabled by either Social Security or the State Disability Review Team
- Be at least 16 but under 65 years of age
- Work in a paid position for which all applicable income taxes are paid
- Pay a premium if required (premium payment has not yet been implemented)

Medicare Savings Programs

- The Medicare Savings Programs assist consumers in paying for their Medicare Premiums
  - Qualified Medicare Beneficiary (QMB)
  - Specified Low Income Medicare Beneficiary (SLIMB)
  - Qualified Individual I (QI-1)
  - Qualified Disabled and Working Individuals (QWDI)
- Special single-page application is available

Qualified Medicare Beneficiary - Began in 1988

- Pays for:
  - Medicare Part A and/or Part B premium
  - Co-insurance
  - Deductibles
- An individual can be eligible for QMB only or for QMB and Medicaid
- Income - 100% of Federal Poverty Level
- NO RESOURCE TEST

Specified Low Income Medicare Beneficiary - Began in 1993

- Pays for Medicare Part B premium only.
- Individuals can be eligible for SLIMB only or for SLIMB and Medicaid (with a spenddown).
- The applicant must have Medicare Part A in order to be eligible for the program.
- Income between 100% and 120% FPL
- NO RESOURCE TEST

Qualified Individual I - Began in 1997

- Pays for the Medicare Part B premium only
- Individuals cannot be eligible for QI-1 and Medicaid
- The applicant must already have Medicare Part A
- Income - less than 135% FPL
- No resource test

Qualified Disabled and Working Individual (QDWI) - Began in 1990

- Applicant must be a Disabled Worker under 65 who lost Medicare Part A benefits because of a return to work
- Income up to 200% of the FPL
- Resource Limit
  - $4,000 for Household of 1
  - $6,000 for Household of 2

MEDICAID PAYS FOR MEDICARE PART A ONLY, NOT PART B

Medicare Part D

- "Dual Eligibles" (Medicaid/Medicare recipients) are automatically eligible for the Medicare Low Income Subsidy
  - This includes Medicare Savings Program participants
- They will receive Medicare Part D with no deductible and no "donut hole"
- No monthly premium if enrolled in a "benchmark plan" (under $37.23/mo. in 2014)

Medicare Part D continued

- Persons applying at Social Security for the Low Income Subsidy (also called Extra Help) can have that application be considered for the Medicare Savings Program.
- Information regarding their application will be sent to their county for determination of eligibility for the Medicare Savings Program.

COBRA Continuation Coverage - Began in 1991

- Medicaid can pay the premiums for COBRA Continuation Beneficiaries
- Premium must be cost effective
- Income and Resource Requirements
  - 100% of the Federal Poverty Level
  - Resources
    - $4,000 for a single
    - $6,000 for a couple

AIDS Insurance Continuation - Began in 1991

- COBRA regulations allow Medicaid to pay health insurance premiums for persons with AIDS or HIV related illness who:
  - Are no longer able to work, or
  - Are working a reduced number of hours, and
  - Do not qualify under the COBRA Continuation Coverage Program.
- Income and Resource Requirements
  - Income – Less than 185% of FPL
  - Resources – No resource test
- No Cost-Effectiveness test is required
- Applicant must be ineligible for Full Coverage Medicaid

Family Planning Benefit Program - Began in 2002

- Increase access to family planning services and prevent or reduce the incidence of unintentional pregnancies. Services include:
  - Most FDA approved birth control, emergency contraception services and follow-up care male and female sterilization
  - Preconception counseling/preventive screening/family planning options before pregnancy

Family Planning Benefit Program continued

- Eligibility Requirements
  - Female or male of ANY age
  - Citizen, or in satisfactory immigration status
- Income Under **223%** Federal Poverty Level
- No Resource Test
- One Page Application
- 3 month retroactive period
- Transportation is included in the benefit package
- Now handled directly through NYS

Medicaid Cancer Treatment Program - Began in 2002

To be eligible for Medicaid coverage under the Medicaid Cancer Treatment Program, individuals must:

- Not be covered under any creditable insurance
- Need treatment for breast, cervical, prostate or colorectal cancer or pre-cancerous conditions
- Be ineligible for Medicaid under other eligibility groups.

Medicaid Cancer Treatment Program continued

- Applications taken by the Cancer Services Program Partnership, not DSS.
- Eligibility determined by NYS DOH, not local DSS.
- Income Guidelines
  - 250% of Federal Poverty Level

Medicaid Cancer Treatment Program continued

Peconic Bay Medical Center
1300 Roanoke Avenue
Riverhead, NY 11901
Phone: (631) 548-6322

Cancer Services Program of Suffolk County
Ext.: (631) 548-6320

Care at Home Program - Began in 1982

- Program is for children who are severely physically disabled.
- To be eligible, children must be:
  - Under age 19
  - New York State residents
  - Eligible for Medicaid either when applying with their parents' income counted or with just their own income counted
  - Have medical needs not covered by private insurance

Long Term Home Health Care Program (LTHHCP)

- New Enrollments for this program have ended in Suffolk County
- Existing participants and those in need of similar services must enroll in either Main Stream Managed Care or Managed Long Term Care

Mainstream Managed Care

- Prepaid Capitation Rate paid to HMO for care of Medicaid recipient
- Mandatory Managed Care in Suffolk County since 2001.
- Unless excluded or exempt from participating, Suffolk MA recipients must join a Medicaid Managed Care Plan
- There are five Mainstream Managed Care Plans in Suffolk

Mainstream Managed Care continued

The five Medicaid Managed Care plans in Suffolk are:

- Affinity
- Fidelis
- Healthfirst
- HIP
- United Healthcare

Mainstream Managed Care cont.

- Services included under Fee for Service Medicaid, but not included in Managed Care package, are provided by Medicaid as "Carved Out Services"
  - Family Planning (for plans not including this optional service)
  - Outpatient Chemical Dependence Services

New York Medicaid CHOICE

- New York Medicaid CHOICE is the education and enrollment broker for Suffolk County Medicaid and Family Health Plus Managed Care
- Consumers should call New York Medicaid CHOICE for information on exemptions and exclusions as well as enrollment.

1-800-505-5678

Managed Long Term Care

- Managed Long Term Care – Authorized to provide or arrange for health and long term care services
  - Elderserve
  - GuildNet
  - HIP MLTC
  - VNS Choice
  - Fidelis Care at Home
  - Aetna Better Health
  - AgeWell New York
  - Elderplan (Homefirst)
  - Wellcare Advocate
  - Integra MLTC, Inc.
  - Extended
  - North Shore LIJ
  - Centerlight Healthcare Select

Managed Long Term Care

- MAP Medicaid Advantage Plus
  - Guildnet Gold
  - HIP VIP
- PACE Program All-inclusive Care for Elderly
  - Centerlight Healthcare (PACE)
- Medicaid Advantage – Provide Medicaid coverage for persons also enrolled in the plan's Medicare Advantage Program
  - HIP
  - Wellcare

Mandatory MLTC Enrollment

- Began roll-out in NYC late 2012
- Nass/Suff/West began roll-out January 2013

Most Dual-eligible (Medicaid/Medicare) recipients seeking home care services are now required to enroll in a MLTC Plan

New York Medicaid Choice

1-800-505-5678

What Is Chronic Care?

Chronic care is the branch of Medicaid that provides coverage for a higher level of care than routine or emergency services.

Chronic care MA provides coverage for people who are:

- receiving services in a nursing home;
- receiving services in an intermediate care facility (ICF);
- receiving services in a hospital at an alternate level of care

What Is Chronic Care?

Chronic care Medicaid does not provide coverage for:

- Home care;
- Adult day care;
- Lombardi Program (LTHHC); or
- Waivered services

These services are covered under community Medicaid

Applying for Chronic Care

- No referrals are needed to apply for chronic care MA, but a person must be in receipt of services and need coverage in order for eligibility to be determined.
- Applicants should submit a signed and completed DOH-4220 (Access NY Healthcare Application) and Supplemental A (a completed LDSS-2921 is also acceptable)

Applying for Chronic Care

- Recipients of community Medicaid can notify the Agency of a change in need due to a nursing home admission that is expected to last 30 days or more.
- Upon receipt of a signed and completed application or request for a change in need, the Applicant will be mailed an acknowledgement letter and the case will be assigned to an examiner.

Applying for Chronic Care

- An Applicant may apply for themselves (personally or via a legal guardian or POA), or through a representative with written authority
  - Authorization must come from the Applicant or someone with legal authority to act on the Applicant's behalf, such as a Court appointed guardian or power of attorney

General Eligibility Requirements

- Applicants for chronic care must document:
  - that they are in receipt of chronic care MA services
  - marital status as spouses are legally responsible for one another
  - Suffolk County residence or that Suffolk is otherwise fiscally responsible for them
  - third party health insurance they possess as MA is the payer of last resort
  - Applicants may attest that they are a citizen or document their qualifying alien status

Resource Eligibility

- Resource documentation for the 60 months prior to the month of application must be reviewed in determining eligibility.
- This applies to all accounts, stocks, bonds, life insurance, real property, etc. owned at any time during the look back period.
- An Applicant's resources as of the first of the month they are seeking coverage are totaled and compared to the MA Resource Allowance.

Resource Eligibility

- This includes all resources owned by the Applicant and/or the community spouse; either solely, jointly with each other or jointly with someone else.
- Refusal by the spouse of an institutionalized applicant/recipient to provide documentation of their income and resources is grounds for denial or discontinuance.

Resource Eligibility

Resources in excess of the Allowance may be spent down in the following manner:

- assigned to the community spouse to raise them to the community spouse resource allowance (CSRA);
- used to purchase a pre-paid funeral;
- used to pay medical bills;
- applied toward unpaid (viable) medical bills.

Income Eligibility

The chronic care budgeting methodology, allows for the following deductions:

- a $50.00 Personal Needs Allowance ($35.00 in an ICF)
- Health Insurance premiums
- an amount necessary to raise the community spouse's income up to the minimum monthly maintenance needs allowance (MMMNA)
- any expenses incurred for medical care, services or supplies not paid by MA or insurance.

Income Eligibility

- Institutionalized individuals in permanent absence status are subject to the chronic care budgeting methodology.
- Any income remaining after applying the allowable deductions is applied to the cost of care on a monthly basis.

Transfers

- The 60 month resource review is primarily to determine if the Applicant and/or their spouse made any uncompensated transfers, which would result in a period of ineligibility.
- A transfer is considered uncompensated when the applicant, their spouse, or someone acting on their behalf makes a voluntary transfer of countable assets for less than fair market value.

Married MLTC Enrollees

- Married Medicaid recipients who are enrolled in a Managed Long Term Care (MLTC) Plan are considered institutionalized and are therefore subject to the chronic care budgeting methodology.
- These persons are not subject to transfer penalties and do not require a 60 month resource review unless they are admitted to a skilled nursing facility for 30 or more days.

Moving Medicaid From County to County

- Effective 1/1/2008 New York State allowed transfers of Medicaid eligibility when an eligible recipient moves from one county to another
  - No break in coverage
  - No need to reapply in new county
  - At least 4 months of coverage in new county before recertification

Suspension of Medicaid for Incarcerated Individuals

- Effective 4/1/2008 New York State allowed suspension of Medicaid eligibility for incarcerated individuals
  - For those in New York State or local prisons/jails – not federal prisons
  - Receives Inpatient Coverage only while incarcerated
  - No need to reapply upon release from prison/jail
  - Recertified 4 months after release

Suspension of Medicaid for Individuals in Psychiatric Center

- Effective 4/1/2011 New York State allowed suspension of Medicaid eligibility for individuals in a psychiatric center
  - No need to reapply upon release
  - Districts notified daily of individuals released
  - Recertified 4 months after release

Where to Send the Medicaid Application

- Riverhead Center (Zip Code List)
- Smithtown Center (Zip Code List)
- DSS Administration Offices in Ronkonkoma (for Chronic Care Only)

How to apply in 2014 and beyond

- Most consumers who are aged, blind, or disabled with Medicare must still complete an application and submit it to DSS.
- MAGI consumers must apply for health insurance through the New York State of Health
  - Call NY State of Health at 1-855-355-5777
  - Or Go Online at: http://www.nystateofhealth.ny.gov
  - Visit a certified counselor/navigator

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Certified Application Counselors

- Certain DSS Medicaid staff have been designated as Certified Application Counselors.
- CAC staff provide application counseling services for in-person MAGI applicants at our 2 MA sites.
- This includes answering questions, scanning documents, and, if necessary, completing the data entry on the NYSOH site.

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Medicaid Under the ACA

The Affordable Care Act, together with Medicaid Redesign initiatives, has resulted in major changes to the NYS Medicaid Program

- New Eligibility groups – Certain populations will no longer obtain coverage from the local DSS
- New eligibility guidelines – Medicaid is expanding and will cover a larger portion of the population
- New methods to obtain coverage – A new online web portal, as well as new community agencies authorized to process applications

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Medicaid Expansion

- New York is one of several States that has opted to expand Medicaid coverage to a new eligibility population that includes single adults.
- Family Health Plus is being eliminated 12/31/14, but many formerly on FHP will now be covered by Medicaid with eligibility expanded to 138% FPL.
- For those between 138 – 150%, NYS will subsidize the Premium on the Exchange so that they will have no premium. They will have the federal cost-sharing subsidy.

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MAGI vs. Non-MAGI

Non-MAGI	MAGI
SSI cash recipients	Pregnant women
SSI-R and ADC-R medically needy	Infants and Children < 19
Residents of nursing homes, institutions, congregate care, adult homes, residential treatment facilities	NEW Adult group Not pregnant Age 19-64 (19 and 20 living alone) No Medicare*
Waiver children and adults	Parents/Caretaker relative (any age)
Medicare Savings Program	Presumptive Pregnant Women
MBI-WPD (Working Disabled)	Family Planning Benefit Program
MCTP (Cancer Treatment Program)	
Disabled Adult Children	
Aged 65, non-caretaker relative	
<Aged 65 w/Medicare non-caretakers	

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Who Is Responsible?

Retained by DSS	Handled by NYS
PCAP applicants	Pregnant Women
SSI Recipients	Infants and Children under 19
Consumers with a spenddown	19-64 yr olds without Medicare
Aged 65 and over	Parents/Caretaker Relatives
Non-parents/caretakers with Medicare	Family Planning Benefit Program
Separate Determinations from TA	
Medicare Savings Program	
Adult Home/Assisted Living/Nursing Home	
Waiver/Specialized MA programs	
Existing cases (Pre-ACA)	
Applications for retroactive coverage*	
Applications from Hospitals*	** for DOS prior to 4/1/14*

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New Category: What is MAGI?

- MAGI stands for "Modified Adjusted Gross Income." It is a federal income tax term.
- People in the "MAGI" category will have eligibility determined counting income using federal income tax rules.
- For families with children, as well as singles and childless couples this will change how income is used to calculate eligibility.

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MAGI Eligibility Guidelines

- Household Composition
  - Based on taxpayer status, not legal responsibility
- Income
  - Uses Modified Adjusted Gross Income
  - Eliminates existing income disregards
  - Follows IRS rules for disregarding certain incomes

MAGI vs. Non-MAGI

- Children under 21 and Parents/caretaker relatives may still "spend down" using the old rules, if they do not qualify for Medicaid using MAGI budgeting.
- Recipients in the MAGI group will be eligible for 12 continuous months of coverage, regardless of changes in income.
- Undocumented Immigrants will be able to obtain coverage for Emergency Services Only via the new process.
- MAGI Consumers with existing Medicaid coverage will renew through the local DSS office, but will be subject to MAGI-Like rules.
  - Consumers in the household will be added to existing cases, as appropriate

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Income Data-Matching

- Data-matching will be used by the Health Exchange to verify an applicant's income attestation.
- If a discrepancy exists (10% above or below), the system will request documentation from the consumer.
- Consumers are also able to provide a reason for any discrepancies.
- State agencies are prohibited from requiring additional documentation when the attested income is within reasonable compatibility.

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Converted Eligibility Levels

Category	Pre-ACA Level	2014 Level
Pregnant Women	200% FPL	223% FPL
Infants	200% FPL	223% FPL
Child 1-18	133% FPL	154% FPL
Parents/Caretaker Relatives	150% FPL	138% FPL
19 & 20 year olds living w/parents	150% FPL	155% FPL
S/CC & 19 & 20 yr olds living alone	100% FPL	138% FPL
Family Planning Benefit Program	200% FPL	223% FPL
< 26 who were in foster care when age 18	NO INCOME LIMIT	

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Why the new levels?

- Under the ACA, consumers who were previously eligible for Medicaid should remain eligible.
- Consumers will no longer receive any of the existing income deductions.
- The new levels take into account the previous deductions, as well as the %5 deduction that is now standard for MAGI budgeting.
- These levels were determined by CMS.

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Options beyond Medicaid

- Children under 19 – CHP – up to 400% FPL.
- Parents/ Caretaker relatives of children <18
  - Spend-down, using pre-ACA budgeting rules
    - OR -
  - Buy Insurance on Exchange and get Subsidies:
    - Premium Tax Credit – up to 400% FPL and
    - Cost-Sharing Assistance – up to 250% FPL
- Singles/Childless Couples and age 20-21 not living with parents - cannot spend-down, can buy Insurance on Exchange with premium & cost-sharing subsidies. (during open enrollment)

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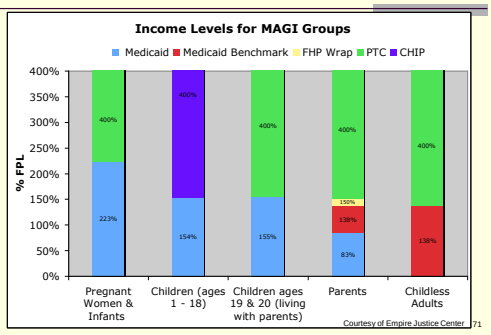
MAGI Income & Benefit Levels



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Exchange Referrals to LDSS

- Consumers who apply through the Health Insurance Marketplace may trigger a referral to the local DSS MA office.
- Referrals can be for a number of reasons:
  - Medicaid eligibility determination of spend-down
  - Blind, disabled or chronically ill
  - Aged 65 or older
  - Requests for home care or waiver services
  - Applications for nursing home care

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The Future of Medicaid

- During 2015, DSS will continue to be responsible for all active cases, regardless of category
- DSS will continue to process new applications for the populations NOT included in the NYSOH (Exchange)
- Future enhancements will expand the NYSOH to include additional populations
- There is no set timeline for this transition at this time

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Questions?